

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2011	
NAME OF PROVIDER OR SUPPLIER  CLARK REHABILITATION AND SKILLED NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129			
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F0000	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00090093 and IN00090287 completed on May 13, 2011.</p> <p>This visit was in conjunction with the PSR to the Recertification and State Licensure Survey completed on April 29, 2011.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaint IN00090903 completed on June 7, 2011.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00092920 completed on July 7, 2011.</p> <p>Complaint IN00090093 - Not corrected.</p> <p>Complaint IN00090287 - Not corrected.</p> <p>Survey date: July 5, 6, 7, 2011</p> <p>Facility number: 000059 Provider number: 155697 AIM number: 100266560</p> <p>Survey team: Donna Groan RN, TC Avona Connell RN [July 6, 7, 2011] Gloria Reisert MSW</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/29/2011

FORM APPROVED

OMB NO. 0938-0391

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	Dorothy Navetta RN  Census bed type: SNF: 9 SNF/NF: 59 Total: 68  Census payor type: Medicare: 12 Medicaid: 49 Other: 7 Total: 68  Sample: 6  These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.  Quality review completed 7/12/11 Cathy Emswiller RN						

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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview the facility failed to ensure missing resident medication was thoroughly investigated for 1 of 1 resident reviewed with missing medications in a sample of 6. (Resident</p>			F0225	<b>F225 – It is the practice of this facility to ensure all alleged violations involving mistreatment, neglect, or abuse, including injuries of</b>		07/19/2011

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	B)  Findings include:  On 7/5/11 at 10:55 a.m., the interim DNS (Director of Nursing Services)#1 provided incidents reported to the Indiana State Department of Health since May 27, 2011. Of the incidents reviewed was the following: "Resident d/c'd (discharged) to home. Meds discovered and given to [named DNS #1] and put in DNS desk...Summary of investigation: Missing Narcs unable to substantiate if company property stolen. Statements from DNS #1, housekeeper #1 obtained. Housekeeper #1 last seen in drawer of DNS office and was not authorized for this. Housekeeper #1 was searched no findings. Drug Test Administered and awaiting results. compliant so far with investigation however interviews still being conducted." signed by the Executive Director 6/29/11."  A signed statement by RN #1 dated 6/28/11 indicated the following: "Around 11:00 a.m. on 6/28/11 I was in the DON office looking for the wound binder. I opened the right hand bottom drawer and saw a large amount of narcotics. I shut the drawer after seeing them. I did not leave the office after seeing them. DNS #1 came in and I told her what I saw. We				<b>unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in process. The following is the facility plan of action for submission and a request for desk review.</b>  <b>What corrective measures were taken for the resident affected by the alleged deficient practice?</b> <ul style="list-style-type: none"> <li>· Resident is no longer in facility.</li> <li>· Resident was contacted and had no concerns.</li> <li>· MD notified.</li> <li>· Police report was made.</li> <li>· Random drug tests submitted and awaiting final results for employees who were last seen in area where missing medications were</li> </ul>		

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	<p>then verified and destroyed the narcotics that were there. I found a few count sheets on the floor and that's when we discovered there were missing narcotics. When I first arrived [named} housekeeper #1 was in here vacuuming (sic). He left when I came in. Later I went to the nurses station and looked though (sic) a chart, and when I came back in [named] housekeeper #1 was in here again going though (sic) the drawers saying he was looking for white out. I jokingly (sic) said what do you keep doing in here every time I leave and he said it is the best place to hide in the building."</p> <p>On 7/5/11, in interview with DNS #1 at 1:10 p.m., she indicated the incident was not reported to the state agency nor were police called. She indicated the drawer, where the medications were placed was not locked and there were a ton of meds in the drawer. She and another nurse destroyed the medications. The Oxycodone were missing.</p> <p>The clinical record for Resident B was reviewed on 7/6/11 at 8:40 a.m. The resident's diagnoses included but were not limited to anxiety and status post fractured left hip. Signed physician orders dated 6/20/11 included, but was not limited to: " Oxycodone (for pain) 10 mg (milligram) po (by mouth) q. (every) 8</p>				<p>stored.</p> <ul style="list-style-type: none"> <li>Initial and five day report was made to the ISDH.</li> </ul> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <ul style="list-style-type: none"> <li>Medication Carts had been audited for discontinued narcotic medications and destroyed per facility protocol on 7/12/11.</li> <li>Nursing staff was interviewed by DNS or Nurse consultant on or before 7/12/11 with no further knowledge of missing narcotics.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>Nursing staff was educated on 7/8/11 through 7/19/11 regarding Policy and Procedure for Discontinued Drugs completed by DNS/Designee.</li> <li>All staff will be inserviced by ED/Department Manager on Abuse Policy and Procedure by 7/19/11.</li> </ul>		

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	<p>hours routine for pain."</p> <p>The resident was discharged on 6/20/11. The Medication Count Sheet for Controlled Medications delivered on 6/14/11 indicated 180 Oxycodone 5mg tablets were dispensed to the facility. Of the 180 sent 152 were remaining on 6/20/11. Twenty-eight tablets were dispensed between 6/16/11 at 0600 (6 a.m.) through 2 p.m. on 6/20/11.</p> <p>On 7/5/11 at 1:45 p.m., Corporate Nurse #1 provided the facility policy and procedure for Discontinued Drugs which included, but were not limited to: "Purpose: To ensure all discontinued medications are disposed of according to federal and state regulations. Procedures: 16.01 Controlled scheduled II - V medications cannot be returned to the pharmacy, they must be destroyed at in the facility according to the facility's medication destruction policy and procedure. 16.02 Controlled Medications: When a controlled medication is discontinued it must be pulled from the med cart by the nurse and destroyed in the facility, according to the facility's established policy and procedures..."</p> <p>On 7/5/11 at 3:30 p.m., DNS #1 provided the policy and procedure 17.0</p>				<ul style="list-style-type: none"> <li>All investigations of allegations of misappropriations of resident property including missing narcotics will be reported within 24 hours to the ISDH and police report will be made when applicable.</li> <li>All investigations will be thoroughly investigated by ED/DNS or designee in place of absence within 5 working days of the incident.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>Medications carts will be audited weekly for four weeks, then monthly for 3 months then quarterly thereafter by DNS/designee and data collected will be submitted to the CQI committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process.</li> <li>Any unusual occurrences will be thoroughly investigated and reported by ED/DNS or designee in a timely manner from the results</li> </ul>		

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	<p>"DISPOSITION OF MEDICATIONS WHEN A RESIDENT IS DISCHARGED: Purpose: To establish a policy and procedure that meets federal and state requirements regarding the disposal of medications when a resident is discharged from the facility. Procedure: Upon discharge for the facility, the patient's drugs are to: (1) Be released with the patient, (2) Be returned to the pharmacy for credit, or (3) Be destroyed by two licensed nursing personnel..." DNS #1 also provided the CQI (Continuous Quality Improvement) which included, but was not limited to: "Controlled substances are stored appropriately and double locked</p> <p>On 7/5/11 at 9:30 a.m., DNS #1 provided the ABUSE PROHIBITION, REPORTING, AND INVESTIGATION POLICY AND PROCEDURE DATED (FEBRUARY 2010) " #16 The Executive Director or the Director of Nursing is responsible to coordinate all investigation processes, assure an accurate and complete written record of the incident and investigation, and to file up a written report to the Indiana State Department of Health within five (5) working days."</p> <p>On 7/7/11 at 4:55 p.m., DNS #1 was queried, if the police were notified of the missing narcotics and she responded</p>				<p>of the medication cart audits. · SSD/designee will submit a summary report of findings will be submitted though the monthly CQI meetings and any substandard findings will be addressed as necessary weekly for four weeks, then monthly for 3 months then quarterly thereafter by DNS/designee and data collected will be submitted to the CQI committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process. ·</p> <p><b>By what date the systemic changes will be completed?</b> · <b>7/19/11</b></p>		

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F0226 SS=D	<p>"No."</p> <p>This deficiency was cited on 5/13/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(d)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure its policy was followed related to investigation of missing medications for 1 of 1 resident reviewed related to missing medications in a sample of 9. (Resident B)</p> <p>Findings include:</p> <p>On 7/5/11 at 10:55 a.m., the interim DNS (Director of Nursing Services)#1 provided incidents reported to the Indiana State Department of Health since May 27, 2011. Of the incidents reviewed was the following: "Resident d/c'd (discharged) to home. Meds discovered and given to [named DNS #1] and put in DNS desk...Summary of investigation: Missing Narcs unable to substantiate if company property stolen. Statements from DNS</p>			F0226	<p><b>F226 –It is the intent of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The following is the facility plan of action for submission and a request for desk review.</b></p> <p><b>What corrective measures were taken for the resident affected by the alleged deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Resident is no longer in facility.</li> <li>· Resident was contacted and had no concerns.</li> <li>· MD notified.</li> </ul>		07/19/2011

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	<p>#1, housekeeper #1 obtained. Housekeeper #1 last seen in drawer of DNS office and was not authorized for this. Housekeeper #1 was searched no findings. Drug Test Administered and awaiting results. compliant so far with investigation however interviews still being conducted." signed by the Executive Director 6/29/11."</p> <p>A signed statement by RN #1 dated 6/28/11 indicated the following: "Around 11:00 a.m. on 6/28/11 I was in the DON office looking for the wound binder. I opened the right hand bottom drawer and saw a large amount of narcotics. I shut the drawer after seeing them. I did not leave the office after seeing them. DNS #1 came in and I told her what I saw. We then verified and destroyed the narcotics that were there. I found a few count sheets on the floor and that's when we discovered there were missing narcotics. When I first arrived [named} housekeeper #1 was in here vacuuming (sic). He left when I came in. Later I went to the nurses station and looked though (sic) a chart, and when I came back in [named] housekeeper #1 was in here again going though (sic) the drawers saying he was looking for white out. I jokingly (sic) said what do you keep doing in here every time I leave and he said it is the best place to hide in the building."</p>				<ul style="list-style-type: none"> <li>Police report was made.</li> <li>Random drug tests submitted and awaiting final results for employees who were last seen in area where missing medications were stored.</li> <li>Initial and five day report was made to the ISDH.</li> <li>ED reviewed the Policy and Procedure for Abuse prohibition, investigation, and reporting by the Director of Operations 7/14/11.</li> </ul> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <ul style="list-style-type: none"> <li>Medication Carts had been audited for discontinued narcotic medications and destroyed per facility protocol on 7/12/11.</li> <li>Nursing staff was interviewed by DNS or Nurse consultant on or before 7/12/11 with no further knowledge of missing narcotics.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to</b></p>		

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	<p>On 7/5/11, in interview with DNS #1 at 1:10 p.m., she indicated the incident was not reported to the state agency nor were police called. She indicated the drawer, where the medications were placed was not locked and there were a ton of meds in the drawer. She and another nurse destroyed the medications. The Oxycodone were missing.</p> <p>The clinical record for Resident B was reviewed on 7/6/11 at 8:40 a.m. The resident's diagnoses included but were not limited to anxiety and status post fractured left hip. Signed physician orders dated 6/20/11 included, but was not limited to: " Oxycodone (for pain) 10 mg (milligram) po (by mouth) q. (every) 8 hours for pain."</p> <p>The resident was discharged on 6/20/11. The Medication Count Sheet for Controlled Medications delivered on 6/14/11 indicated 180 Oxycodone tablets were dispensed to the facility. Of the 180 sent 152 were remaining on 6/20/11.</p> <p>On 7/5/11 at 1:45 p.m., Corporate Nurse #1 provided the facility policy and procedure for Discontinued Drugs which included, but were not limited to: "Purpose: To ensure all discontinued medications are re disposed of according to</p>				<p><b>ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>Nursing staff was educated on 7/8/11 through 7/19/11 regarding Policy and Procedure for Discontinued Drugs completed by DNS/Designee.</li> <li>ED reviewed the Policy and Procedure for Abuse prohibition, investigation, and reporting by the Director of Operations on 7/14/11 to ensure for compliance.</li> <li>All staff will be inserviced by ED/Department Manager on Abuse Policy and Procedure by 7/19/11.</li> <li>All investigations of allegations of misappropriations of resident property including missing narcotics will be reported within 24 hours to the ISDH and police report will be made when applicable.</li> <li>All investigations will be thoroughly investigated by ED/DNS or designee in place of absence within 5 working days of the incident.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be</b></p>		

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	<p>federal and state regulations. Procedures: 16.01 Controlled scheduled II - V medications cannot be returned to the pharmacy, they must be destroyed at in the facility according to the facility's medication destruction policy and procedure. 16.02 Controlled Medications: When a controlled medication is discontinued it must be pulled from the med cart by the nurse and destroyed in the facility, according to the facility's established policy and procedures..."</p> <p>On 7/5/11 at 3:30 p.m., DNS #1 provided the policy and procedure 17.0 "DISPOSITION OF MEDICATIONS WHEN A RESIDENT IS DISCHARGED: Purpose: To establish a policy and procedure that meets federal and state requirements regarding the disposal of medications when a resident is discharged from the facility. Procedure: Upon discharge for the facility, the patient's drugs are to: (1) Be released with the patient, (2) Be returned to the pharmacy for credit, or (3) Be destroyed by two licensed nursing personnel..." DNS #1 also provided the CQI (Continuous Quality Improvement) which included, but was not limited to: "Controlled substances are stored appropriately and double locked</p>				<p><b>put into place?</b></p> <ul style="list-style-type: none"> <li>Medications carts will be audited weekly for four weeks, then monthly for 3 months then quarterly thereafter by DNS/designee and data collected will be submitted to the CQI committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process.</li> <li>Any unusual occurrences will be thoroughly investigated and reported by ED/DNS or designee in a timely manner from the results of the medication cart audits.</li> <li>The director of operations will be notified and review any unusual occurrences that is investigated and reported by ED/DNS to ensure for compliance.</li> <li>SSD/designee will submit a summary report of findings will be submitted though the monthly CQI meetings and any substandard findings will be addressed as necessary weekly for four weeks, then monthly for 3 months then quarterly thereafter by DNS/designee and data</li> </ul>		

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F0282 SS=D	<p>On 7/5/11 at 9:30 a.m., DNS #1 provided the ABUSE PROHIBITION, REPORTING, AND INVESTIGATION POLICY AND PROCEDURE DATED (FEBRUARY 2010) " #16 The Executive Director or the Director of Nursing is responsible to coordinate all investigation processes, assure an accurate and complete written record of the incident and investigation, and to file up a written report to the Indiana State Department of Health within five (5) working days."</p> <p>This deficiency was cited on , 5/13/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(a)</p>				<p>collected will be submitted to the CQI committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process.</p> <p><b>By what date the systemic changes will be completed?</b> 7/19/11</p>		
	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>A. Based on record review and interview the facility failed to ensure the resident plan of care was followed to change the</p>			F0282	<p><b>F282 It is the intent of this facility to ensure that the plan of care is followed to change site of a PICC line per</b></p>		07/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2011	
NAME OF PROVIDER OR SUPPLIER  CLARK REHABILITATION AND SKILLED NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129			
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	<p>             dressing site of the PICC (Peripherally Inserted Central Catheter) line were completed for 1 of 2 residents reviewed with a PICC line in a sample of 9. (Resident C)           </p> <p>             B. Based on record review and interview, the facility failed to follow a physician's order for blood pressure monitoring for 1 of 1 resident reviewed in a sample of 9 for blood pressure monitoring. (Resident C)           </p> <p>             C. Based on observation, record review and interview the facility failed to ensure physician orders were followed for skin treatment for 1 of 3 residents reviewed with skin issues in a sample of 6. (Resident G).           </p> <p>Findings include:</p> <p>             A. On July 6, 2011 at 11:10 a.m., in interview with Resident C, she indicated her dressing was to be changed Friday, July 2. She indicated she asked the nurse, who indicated she'd be back, but did not return. Last night, July 5 th, she indicated RN #1 changed the dressing.           </p> <p>             The clinical record for Resident C was reviewed on 7/5/11 at 9:55 a.m. The resident's diagnoses included, but were not limited to MRSA (Methicillin           </p>				<p> <b>physician orders, blood pressures per physician order and physician orders are followed for skin treatment. The following is our plan of correction for the citations and the facility is requesting a desk review.</b>  <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> </p> <ul style="list-style-type: none"> <li>Resident C: PICC line dressing was changed the following day, Nurse that missed treatment was educated and counseled. MD notified new order received treatment no longer necessary and PICC line discontinued.</li> <li>Resident C: MD notified and new order received to discontinue daily blood pressures as no longer necessary.</li> <li>Resident G: Skin was cleansed and appropriate treatment was applied as MD ordered.</li> </ul> <p> <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> </p> <ul style="list-style-type: none"> <li>100% audit of all resident's with PICC line, Bp monitoring orders and skin treatments completed with no</li> </ul>		

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	<p>Resistant Staphylococcus Aureus), Acute Embolism (blood clot) and diabetes mellitus. The resident returned from the hospital on 6/24/11 with a PICC Line. The Medication Record dated 6/24/11 through 6/30/11 which included, but was not limited to PICC/MIDLINE "Change dressing 24 hours after insertion then every 7 days using Transparent Dressing... All orders have been verbally verified with Prescriber and initialed by the nurse. "Documentation was lacking of a change on 6/25/11 and July 2.</p> <p>The July 2011 Medication Administration Record indicated a dressing change was due on July 4, and initialed as done on July 5, 2011.</p> <p>On 7/6/11 at 11:40 a.m., RN #2 provided the policy and procedure for Peripherally inserted central catheter (PICC LINE) post-insertion catheter maintenance Policies: 1. Dressings are to be changed every week* using sterile technique (see procedure for Central Line Dressing Change)..."</p> <p>B. The clinical record for Resident C was reviewed on 7/5/11 at 9:55 a.m. The resident's diagnoses included, but were not limited to MRSA (Methicillin Resistant Staphylococcus Aureus) an infection in the blood, Acute Embolism</p>				<p>other resident's identified.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>Nurses were educated by DNS/designee on 7/8/11 through 7/19/11 regarding following MD orders to include but not limited to PICC line dressing changes, Blood pressure monitoring and skin treatments.</li> <li>MARs/TARS will be auditing weekly x 4 then monthly x 3 by DNS/designee for PICC line dressing changes, Blood pressure monitoring and skin treatments to ensure MD orders are followed.</li> <li>DNS/designee will observe a minimum of 2 nurses weekly until all nurses have completed a validation of treatment completed per MD order. All new nurses will be validated during his/her orientation on the expectations of following MD orders.</li> <li>Audits will be reviewed by DNS/designee to ensure for compliance; failure to comply and a progressive disciplinary action with nurses</li> </ul>		

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	<p>(blood clot) and diabetes mellitus. The May 2011 signed Physician Orders included, but were not limited to Check BP (blood pressure) Q (every) day. Notify MD if BP above 160/90.</p> <p>Review of the June 2011 Medication Record included, but was not limited to "Check blood pressure once daily notify MD if blood pressure &lt; (sic) 160/90 for 3 -11 shift. The blood pressures were not taken and recorded on June 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13, 18, 19, 20. In interview with the Medical Records Director on 7/5/11 at 12:10 p.m., she found blood pressure measurements for 6/2/11 124/80 8 p.m., 6/9/11 122/82 9 p.m., 6/11/11 120/71 3 a.m., 6/14/11 102/75 5:30 p.m. Blood pressures which were taken were not greater than 160/90 as per the MD order.</p>				<p>as applicable.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>DNS/Designee to review 24 hour report and orders in am meeting daily, Mon-Fri excluding weekends and holidays a week for residents to include but not limited to PICC lines, Blood pressure monitoring and skin treatments.</li> <li>DNS/Designee will audit treatment and/or medication record to assure orders to include but not limited to PICC dressings, blood pressures and skin treatments are completed as ordered.</li> <li>All audits will be reviewed by IDT daily in AM meeting Mon-Fri excluding weekends and holidays to ensure completion.</li> <li>Monitoring will be weekly times one month, then monthly for 6 months and data collected will be submitted to the CQI committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process.</li> </ul> <p><b>By what date the systemic changes will be completed?</b></p> <ul style="list-style-type: none"> <li>July 19, 2011</li> </ul>		

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	<p>C. On 07/06/11 between 4:05 p.m. 4:34 p.m. care was observed for resident G. Certified Nursing Assistants #1, and #2 entered the resident's room to provide peri care. The resident's peri area, buttocks, groin and inner thighs was observed be coated with a white pasty substance. CNA #1, wet wash cloths with warm water and sprayed a no rinse cleanser on the cloth to cleanse the resident. Each time the CNA wiped the resident the resident cried out "that hurts." There was nothing in place to prevent skin on skin as the resident's abdomen was large and had to be lifted up to cleanse the groin area.</p> <p>Licensed Practical Nurse (LPN) #/1, entered the room at 4:16; p.m., with a tube of Desitin (a white ointment used to heal/protect skin) in a plastic bag. He placed the Desitin on the over the bed table. CNA #1, was cleansing the resident's groin area at this time. When queried if the resident needed something to prevent skin on skin LPN #1 replied "I think she needs to get out of bed and get a shower every day." The LPN then picked up the tube of Desitin and left the room.</p> <p>At 4:25 the LPN returned with a tube of Xenaderm and placed it on the over the bed table. The resident continued to complain of burning pain while the CNA</p>			F0282	<p><b>F282 It is the intent of this facility to ensure that the plan of care is followed to change site of a PICC line per physician orders, blood pressures per physician order and physician orders are followed for skin treatment. The following is our plan of correction for the citations and the facility is requesting a desk review.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>Resident C: PICC line dressing was changed the following day, Nurse that missed treatment was educated and counseled. MD notified new order received treatment no longer necessary and PICC line discontinued.</li> <li>Resident C: MD notified and new order received to discontinue daily blood pressures as no longer necessary.</li> <li>Resident G: Skin was cleansed and appropriate treatment was applied as MD ordered.</li> </ul> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <ul style="list-style-type: none"> <li>100% audit of all</li> </ul>		07/19/2011

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	<p>was cleansing the skin. The LPN told the resident "just doing our job; work with us on this you can do it."</p> <p>The LPN applied Xenaderm to the resident's excoriated areas. When CNA #1 finished cleansing the white substance from the resident,, the LPN was queried, at this time, if the treatment was for Xenaderm or Desitin The reply was Xenaderm as the Desitin was for areas under the resident's breast. LPN #1 indicated the white substance appeared to be Desitin.</p> <p>Review of the resident's clinical record on 07/07/11 at 8:20 a.m. indicated the resident had diagnoses including but not limited to: morbid obesity, hypertension, diabetes, congestive heart failure.</p> <p>A telephone order dated 07/01/11 at 2:00 p.m., indicated the following:</p> <ol style="list-style-type: none"> <li>1. D/C (discontinue) Silvadene to buttocks q (every) shift.</li> <li>2. Cleanse buttocks with NS (normal saline), pat dry and apply Xenaderm to buttocks q shift r/t (related to redness).</li> </ol> <p>LPN #1 failed to cleanse the skin with normal saline prior to applying the Xenaderm after CNA #1 cleansed the white pasty substance from the resident.</p>				<p>resident's with PICC line, Bp monitoring orders and skin treatments completed with no other resident's identified.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Nurses were educated by DNS/designee on 7/8/11 through 7/19/11 regarding following MD orders to include but not limited to PICC line dressing changes, Blood pressure monitoring and skin treatments.</li> <li>· MARs/TARS will be auditing weekly x 4 then monthly x 3 by DNS/designee for PICC line dressing changes, Blood pressure monitoring and skin treatments to ensure MD orders are followed.</li> <li>· DNS/designee will observe a minimum of 2 nurses weekly until all nurses have completed a validation of treatment completed per MD order. All new nurses will be validated during his/her orientation on the expectations of following MD orders.</li> <li>· Audits will be reviewed by DNS/designee to ensure</li> </ul>		

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	This deficiency was cited on 6/7/11, 5/13/11, and 4/29/11. The facility failed to implement a systemic plan of correction to prevent recurrence.  3.1-35(g)(2)				for compliance; failure to comply and a progressive disciplinary action with nurses as applicable.  <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place?</b> <ul style="list-style-type: none"> <li>DNS/Designee to review 24 hour report and orders in am meeting daily, Mon-Fri excluding weekends and holidays a week for residents to include but not limited to PICC lines, Blood pressure monitoring and skin treatments.</li> <li>DNS/Designee will audit treatment and/or medication record to assure orders to include but not limited to PICC dressings, blood pressures and skin treatments are completed as ordered.</li> <li>All audits will be reviewed by IDT daily in AM meeting Mon-Fri excluding weekends and holidays to ensure completion.</li> <li>Monitoring will be weekly times one month, then monthly for 6 months and data collected will be submitted to the CQI committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process.</li> </ul>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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